
**RHODE ISLAND HEALTH CARE QUALITY
PERFORMANCE MEASUREMENT
AND REPORTING PROGRAM**

**Eighth Annual Report to the General Assembly
R.I.G.L. 23-17.17-5
2005**

**Rhode Island Department of Health
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RHODE ISLAND HEALTH CARE QUALITY PERFORMANCE MEASUREMENT AND REPORTING PROGRAM

Annual Report - 2005

I. Introduction

The Health Care Quality Performance Measurement and Reporting Program (HCQPMRP) has completed its eighth year with continued national recognition, expanded responsibilities of collecting hospital staffing reports, collaboration on data collection for hospital incident and event reporting, and pursuing public reporting of: home health care patient satisfaction, community health center clinical measures, and a nurse sensitive indicator - pressure ulcers.

A major focus has been to align the program's activities with other national health care quality activities. Sensitivity to health care facilities' limited financial and personnel resources available for this program has guided the program to link HEALTH's website to national web sites reporting quality data on Rhode Island health care facilities wherever such measures are available without additional data collection or analysis (i.e., "Hospital Compare", "Dialysis Compare," and "The National Health Care Quality Report").

The appropriation level (see Section XV) and structure of the HCQPMRP is such that healthcare facilities bear the financial burden for collecting clinical measures and patient satisfaction data. This policy has presented challenges for implementation of the program that have become increasingly evident this year as smaller healthcare facilities, such as home health care providers and home nursing providers, were directed to participate in and fund public reporting. It will be important to monitor the sustainability of the program under this structure as well as the burden it places on the participating facilities.

II. Regulations

In October 2005, the Department of Health (HEALTH) promulgated amendments to the regulations for the Health Care Quality Program (R-23-17.7-QUAL) on the advice of Health Services Regulation. The regulations were amended to be more specific about the enforcement of the regulations. The regulations were also amended to add home health care facilities to the mandatory reporting program. Although the Medicare certified home health agencies publicly report clinical data, all agencies are now regulated to participate in patient satisfaction surveys. Finally, the regulations were amended to include the legislative requirement (Public Law 05-045) that the HCQPMRP collect annual hospital staffing reports, commencing in January 2006. All of these changes in the regulation will become effective in January 2006.

III. Hospitals

The Centers for Medicare and Medicaid Services (CMS) made public its new “consumer-friendly” version of Hospital Compare. This is a web-based tool with quality measures on how often hospitals provide recommended care for adults for certain conditions. Individual hospitals are compared to state and national averages, and the top 10% of hospitals nationwide. Previously, Rhode Island had reported these clinical measures in reports entitled “Hospital Performance in Rhode Island: How Often Our Hospitals Provide Recommended Care for Health Attack, Heart Failure and Pneumonia.” The Rhode Island Reports provided data on composite measures for each condition: heart attack care, heart failure care, and pneumonia care. CMS’ “Hospital Compare” reports individual rather than composite measures, and longitudinal data are not available for comparison. For 13 of the 20 measures collected at time periods between April 2004 and March 2005, the average for all reporting hospitals in Rhode Island was equal to or above the national average of reporting hospitals. The Hospital Measures Subcommittee has requested that our contractor, Qualidigm/ Quality Partners of Rhode Island analyze the data on Hospital Compare and present composite measures for public reporting on HEALTH’s website that includes longitudinal data for comparison.

The public report on hospital patient satisfaction originally planned for publication in 2005 was postponed pending decisions regarding the national implementation of CMS’ patient satisfaction survey, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). HCAHPS has been endorsed and approved by many national organizations including the following: American Hospital Association, AARP, AFL-CIO, American Medical Association, American Nurses Association, Association of American Medical Colleges, Consumer – Purchaser Disclosure Project, Federation of American Hospitals, Joint Commission on Accreditation of Healthcare Organizations, and National Quality Forum. CMS plans to have a voluntary pilot of the survey for discharges in April 2006, with a public survey in the Fall of 2006 and a public report late in 2007. Press Ganey, the hospital patient satisfaction survey vendor for Rhode Island, has incorporated HCAHPS into their survey tool. The Hospital Measures Subcommittee created a workgroup to make recommendations to the Steering Committee regarding implementation of HCAHPS.

The hospitals completed their quality improvement presentations to the Health Care Quality Steering Committee. Hospitals presented quality improvement projects developed out of patient satisfaction survey results. The goal was to share best practices among hospitals. Presentations have continued at the Hospital Measures Subcommittee to enhance discussion and to provide information for planning and decision-making by the Subcommittee.

II. Nursing Homes

The Nursing Home Measures Subcommittee has requested modifications to the clinical data presented on HEALTH's website. This is in response to requests made to the trade organizations by patients and families. Several changes were recommended to improve the website for end-users. The listing of nursing home facilities was ordered according to town, rather than by county. Data are currently presented on a quarterly basis, with historical data available. Modifications to this presentation are being analyzed, to determine whether annual data can be presented longitudinally. A request has also been made to add the results of facility inspections performed by the Office of Facilities Regulation survey information. When available, family and resident satisfaction survey data will also be included. The long range plan is to incorporate these data into HEALTH's interactive web query tool, so that families, and health care personnel can readily access the information they are seeking and organize it in a way that meets their specific requirements.

During the past year, the pilots for the family and resident satisfaction surveys were completed. The family satisfaction surveys were mailed, and the resident surveys were conducted in-person by trained interviewers. Facilities received reports of the survey results for their facilities, compared to the state average. As with the pilot for hospital patient satisfaction, this information was not publicly reported. The information was given to the nursing homes for internal quality improvement efforts. The public reporting phase of the family and resident surveys was initiated in late November, 2005. Data collection will begin in March/April 2006, with a public report anticipated by the end of 2006.

HCQPMRP participated in the development of an annual quality award for nursing homes, "The Rhode Island Nursing Home Challenge." The Challenge was sponsored by a coalition of Rhode Island long-term care stakeholders, and awarded at Quality Partners' annual Healthcare Quality Awards Breakfast. The intent of the award is to identify best practices in sufficient detail so that other facilities are able to replicate the processes. The first annual award was for "Recognition of Long-Term Care Facilities for Reducing or Eliminating Pressure Ulcers." Applicants submitted the following information to the award review panel: demographic data; the most recent high and low risk long term pressure ulcer quality measurements reported to CMS; the most recent state survey information which included the scope and severity of any deficiencies cited; a written description of the pressure ulcer program applied; documented evidence of clinical improvements and/or cost-related information; and a plan to ensure that gains were sustained. Reproducibility, sustainability, and innovation were the key criteria against which the awards were weighed. There were nine applicants and two award winners in the first challenge.

III. Home Health Care

Home health care facilities completed their first year of publicly reporting clinical data. The data reported is from CMS' "Home Health Compare." In Rhode Island, of sixty-four licensed home health care agencies, there are twenty-two home health care agencies certified by Medicare that are required to submit this data to CMS. The data reported includes only those facilities that have been Medicare certified for at least one year. The data are analyzed for Rhode Island, and reported in a numerical (percentage) format, as well as a diamond rating system, indicating whether the score is above, about the same, or below the national reference score. The data are updated quarterly, and contain a full year's data in each upload, (i.e. the rating is for the most recent four quarters of data).

A Home Health Care Subcommittee was established to address patient satisfaction surveys among home health care clients. To date, no other state has publicly reported these data. The primary challenges for this effort were lack of funding and developing a survey tool to serve very diverse populations among the facilities. Some facilities are geared toward short-term patients while others serve long-term patients. Some provide skilled services whereas others provide home care services. The Subcommittee issued an RFP and chose a vendor (Press Ganey) to administer the pilot and publicly reported surveys and to prepare a public report. In order to not create undue financial burden on smaller home health care agencies, Qualidigm/ Quality Partners of Rhode Island and Press Ganey negotiated a sliding scale payment based on the average daily census of the agencies. The Subcommittee developed a survey questionnaire modified from Press Ganey's standard survey, and will seek approval of the questionnaire from the Health Care Quality Steering Committee. Pending Steering Committee approval of the survey questionnaire, Press Ganey will contract with the home health care agencies in February, 2006. It is anticipated that pilot survey data collection will commence sometime in the second quarter of 2006.

IV. Organized Ambulatory Care Centers

The Health Care Quality Steering Committee requested that licensed organized ambulatory care facilities begin to participate in the HCQPMRP program. As the bulk of these facilities included the community health centers of Rhode Island (which also manage the school based health centers), a Community Health Center Subcommittee is being established to address publicly reporting clinical measures. An environmental scan of public reporting of ambulatory care measures is being conducted by Qualidigm/ Quality Partners of Rhode Island. The report will consist of a literature review and an assessment of existing Rhode Island measures as well as existing national measures. The study will be completed by the end of January 2006. The community health centers have identified a work group and measures that would be of benefit to their quality improvement efforts. The Subcommittee will reconvene after receipt of the environmental scan.

V. Nurse Sensitive Performance Indicators

In order to meet the General Assembly's charge to 1) identify patient outcomes potentially sensitive to nursing care; 2) select indicators found to have an empirically supported relationship to staff nursing; and 3) determine the availability of Rhode Island data for possible monitoring, the Health Care Quality Steering Committee requested that the topic of pressure ulcers be considered. Pressure ulcers are viewed as a system-wide issue occurring at home and in nursing homes, not just associated with hospitals. Many hospitals are already tracking this measure for internal quality improvement. Nursing homes are publicly reporting pressure ulcer data through the Minimum Data Set (MDS) that is sent to CMS. These measures include pressure ulcers among high and low risk long-term patients, as well as short-term patients with pressure ulcers.

A workgroup with representatives from the Rhode Island State Nurses Association, United Nurses and Allied Professionals, the Hospital Association of Rhode Island, Blue Cross and Blue Shield, Qualidigm, and HEALTH worked with the Hospital Measures Subcommittee to review existing studies and recommendations regarding publicly reporting pressure ulcers. Several methods were reviewed: the California Nursing Outcomes Coalition (CalNOC) pressure ulcer prevalence study endorsed by the National Quality Forum in their published report, "*National Voluntary Consensus Standards for Nursing-Sensitive Care: An Initial Performance Measurement Set*;" the American Nurses Association National Database of Nursing Quality Indicators (NDNQI) pressure ulcer prevalence study used by several hospitals in Rhode Island; and process measures used by nursing homes. No consensus was reached. In the past, the HCQPMRP has reported clinical process measures rather than outcome measures, due to concerns about risk adjustment. The availability of both financial and human resources to conduct prevalence surveys was an additional concern. The work group is planning to reconvene to make recommendations to the Hospital Measures Subcommittee in February 2006. The Hospital Measures Subcommittee will make recommendations to the Health Care Quality Steering Committee in March 2006.

Mary Jean Schumann, MSN, RN, MBA, CPNP of the American Nursing Association (ANA) presented an "Overview of the National Database of Nursing Quality Indicators" (NDNQI) to the Health Care Quality Steering Committee. It was established in 1998 as part of ANA's Safety and Quality Initiative, and is supported by the ANA and through fees for participation. The two goals for NDNQI are to: 1) provide comparative information to hospitals for use in quality improvement activities, and 2) develop national data for research on the relationship between nurse staffing and patient outcomes. There are 708 hospitals (13% of all general hospitals) participating nationally, seven of them are hospitals in Rhode Island. It is not a random sample as participation is voluntary, and larger hospitals are more likely to participate. These data are not publicly reported.

NDNQI uses unit type as a means of risk stratification for quality measures. Quarterly data are available at the following unit levels: critical care, step down, medical, surgical, combined med-surg, rehabilitation, pediatrics, and psychiatry. The quality indicators include three consensus measures from the National Quality Forum (nursing hours per patient day, skill mix or % RN, and fall rate), as well as RN education & certification,

hospital acquired pressure ulcer rate, pediatric IV infiltration, pediatric pain assessment cycle, and psychiatric injury assault rate. RN satisfaction surveys are available on all units. Hospitals select which indicators they will report to NDNQI.

The comparative information available in NDNQI includes risk stratification of hospital staffed bed size and unit type. The uses for the outcome measures are to support quality initiatives, customer decisions, and risk management. Using NDNQI allows for: quality improvement activities to be measurable on a unit-by-unit basis, staffing data, some risk adjustment, and benchmarking opportunities via national comparisons.

VI. AHRQ Quality Indicators

Quality Analytic Services of the National Perinatal Information Center is preparing a series of public reports on, “Rhode Island Trends in AHRQ Quality Indicators for Patient Safety, Prevention, and Inpatient Quality.” These reports will focus on Rhode Island trends in the AHRQ indicators for 1999-2004. The quality indicators are grouped into three areas with 76 indicators: patient safety (29 provider level rates and 6 area level rates), prevention (16 indicators), and inpatient quality (25 provider rates subdivided into indicators of volume, post- procedural mortality, inpatient mortality, and utilization rates). The national comparative rates are from AHRQ’s National Inpatient Sample-2002.

The patient safety indicators are designed to screen for problems resulting from exposure to the healthcare system that are amenable to prevention by changes at the system or provider level. The prevention quality indicators are ambulatory care sensitive conditions that result in hospital admissions that could have been avoided through high quality outpatient care or that reflect conditions that could be less severe, if treated early and appropriately. The inpatient quality indicators reflect quality of care inside hospitals and include inpatient mortality; utilization of procedures for which there are questions of over use, under use, or misuse; and volume of procedures for which there is evidence that a higher volume of procedures is associated with lower mortality.

The project has included Rhode Island inpatient discharge data from 1999-2004, Healthcare Cost and Utilization Project (HCUP) software and Rhode Island trends at a population level. The data will be presented at the state level, as was done in the report on 1994-1998 data.

VII. Annual Hospital Staffing Report

Chapter 23-17.17-8. -Annual Hospital Staffing Report was enacted as an amendment to the Health Care Quality Program on 6/16/05. Implementation is slated for January 31, 2006. The regulations mirror the law with the addition that the information will be reported “in a manner specified by the Director.” For the first report, HEALTH will accept what hospitals submit in their own format, with the caveat that the information be

understandable for external parties (i.e., type of unit rather than name of unit familiar to only those employed by the hospital). These reports will be available to the public. Modifications in the format will be made for the next report. Information from other states already collecting these data has been solicited and a workgroup will be created to address the report format.

VIII. Health Care Workforce

Dr. Minoo Javanmardian presented, "Help Wanted: The Growing Crisis in Rhode Island's Nursing Workforce" to the Health Care Quality Steering Committee. This was part of SHAPE Phase II, a nursing workforce study. The study was not designed to identify solutions. The study objective was to examine six central nursing workforce issues in RI: nursing workforce profile (age and care setting), factors influencing the supply of nurses, trends in nursing school enrollments (70% in the workforce graduated from a school in RI), projected demand through 2020, current and future supply, demand, and gaps, and potential solutions or options. A broad panel of 22 local experts, conducted by international consultants, guided the study. The methodology consisted of a supply-demand-gap framework, and primary research. The data sources included qualitative data (20 in-depth interviews and focus groups), and quantitative data (a survey of 4,000 RI nurses- with a 70% response rate, and data collection from all care settings). For additional detailed information, please refer to: www.rishape.org.

IX. Hospital Incident and Event Reporting

The Final Report to the Rhode Island General Assembly "Hospital Surveys and Incident and Events Reporting" dated November 2001 made a recommendation that hospital incident and event reporting should be incorporated into the HCQPMRP. During this year, Qualidigm is developing a data system for HEALTH to collect incident and event reporting, using a standardized tool that has the capability to be populated using the web. The tool will be tested in early 2006, after comments have been received from hospital risk managers. Implementation is planned in 2006.

X. Technical Expert Panel

HEALTH convened a one-day Public Reporting Technical Expert Panel (TEP) to evaluate the HCQPMRP public reporting efforts to date and comment on the future direction of the program. TEP members, drawn from local and national leaders in public reporting, discussed comparing health care providers, using longitudinal data, creating composite measures, and ensuring consumer data accessibility. In a report prepared for the Director of Health by Qualidigm and Quality Partners of Rhode Island, the following recommendations were made to HEALTH:

- Continue to use and/or develop comparison methods with statistical and face validity for each healthcare setting;
- Consider creating comparison groups based on empirical goals or thresholds;
- Explore options for creating interactive public reporting formats that include the ability for users to trend information over time;
- Continue to use and/or create composite measures within service line or clinical domain;
- Encourage the use and continued adoption of electronic medical records (EMRs), which will greatly enhance data availability and comprehensiveness for public reporting purposes; and
- Evaluate current and future public reporting formats to ensure that they reflect expert recommendations for format (e.g., color, key message points).

XI. Additional Participation in Public Reporting and Quality Improvement

The National Health Care Quality Report produced by the Agency for Healthcare Research and Quality reported state level data and benchmarked it to national data using 10 databases. The measures included effectiveness of care, timeliness of care, patient centeredness, and overall care in hospitals, nursing homes, home health care agencies, and ambulatory settings. According to one of the authors, Dwight McNeill, PhD, MPH, Rhode Island was rated #1 nationally on the overall healthcare quality index (the ratio of numbers of measures above average to number below average). The report states:

“The *Rhode Island Summary Table* includes 106 measures from the most recent year of data in the 2004 NHQR (For the most recent data year, Rhode Island has 30 measures in the above-average category (compared to all reporting States), 45 in the average category of States, and 10 in the below-average category of States. Rhode Island has 21 measures without sufficient data for classification. Measures in the below-average, and possibly in the average, categories indicate areas that may be fruitful for quality improvement initiatives.”

This report has been linked to HEALTH’s website, for easier access. (<http://www.qualitytools.ahrq.gov/qualityreport/state/stateData.aspx?state=RI>). Going forward, AHRQ will create a Rhode Island Healthcare Quality Dashboard to identify benchmarked data, strengths, and weaknesses to be addressed, based on information in the 10 databases provided by facilities in Rhode Island.

Judith Barr, ScD of Qualidigm, who has been instrumental in the HCQPMRP program since its inception, presented “Physicians’ Views on Public Reporting of Hospital Quality Data,” a presentation previously given to the American Public Health Association by the project team of Dr. Barr, colleagues at Qualidigm, RTI International, Baruch College, and CMS. The purpose of the project was to understand physicians as users of hospital-quality-of-care measures with regard to referral and treatment decisions, as information intermediaries for patients, for patient-initiated discussions of quality, and for quality

improvement in hospitals. The three research questions were: How will physicians react to patients who raise questions about public reports on hospital quality? Will physicians make changes, especially in referral decisions, in response to patient questions about hospital quality? What factors are important to physicians in their assessment and use of data reports on hospital quality? The methodology consisted of qualitative analysis of face-to-face interviews with physicians using realistic patient scenarios. The recommendations included in the report are: educate physicians about the use of public reports, encourage patient-initiated discussions, consider physician influence on quality improvement, continue disseminating hospital public reports to physicians, describe sound methods used, and post reports on public websites.

Richard Gamache, Vice President at Roger Williams Medical Center and Administrator of Elmhurst Extended Care Facility presented “Eden and Elder Care: Opportunities and Innovations.” Elmhurst Extended Care, a 192 bed skilled nursing facility with sub-acute and dementia/ Alzheimer’s special care programs, pursued an alternative approach to nursing home care in 2002, the Eden Alternative. Dr. William Thomas developed an approach that combats loneliness, helplessness, and boredom in nursing homes by creating environments that provide close and continual contact with children, plants, and animals; loving companionship, meaningful activity; variety and spontaneity; and a life worth living. The culture changes implemented include: management realignment; providing education and career opportunities for staff; permanent staff assignments to increase sustained relationships with residents, environmental changes, and empowerment. Since implementing the program, admissions have declined, average occupancy has increased, discharges to hospitals have decreased, expirations have decreased, geriatric depression scales have decreased, mini mental status exam scores have increased, satisfaction surveys have improved, and staff turnover has decreased. For additional information, the following websites were recommended: www.elmhurstextendedcare.org, www.edenalt.com, www.nagna.org, and www.matherlifeways.org.

XII. Health Care Quality Performance Measurement and Reporting Program: 2006 Program Goals

- I. Overall Program
 - A. Incorporate technical expert panel recommendations into program activities
 - B. Enhance program access by utilizing HEALTH’s web query tool for interactive public reporting
 - C. Send out a Request for Proposal and select a Contractor to assist with program implementation
 - D. Assure sufficient finding (state, federal, and/or grant) to support the goals and assure the quality of the program

- II. Hospitals
 - A. Monitor national trends in hospital public reporting requirements for clinical measures and patient satisfaction
 - B. Create a web based composite report for Rhode Island's required hospital clinical measures and post it on the HEALTH website with longitudinal data for comparison
 - C. Resume public reporting of patient satisfaction
 - D. Continue to share best practices for quality improvement
- III. Nursing Home Facilities
 - A. Incorporate the quarterly updates of nursing home clinical measures, facility regulation survey data into HEALTH's web query tool
 - B. Complete the family and resident satisfaction surveys for public reporting, finalize the public report format, and develop a format for HEALTH web query tool
- IV. Home Health Care Agencies
 - A. Continue the quarterly updates of home health clinical measures and develop a format for incorporation into HEALTH's web query tool
 - B. Implement the patient satisfaction pilot survey and develop the format for public reporting
- V. Community Health Centers
 - A. Receive final environmental scan for ambulatory care measures to inform pursuit of public reporting
 - B. Reconvene Community Health Center Subcommittee to finalize clinical measures to be piloted and publicly reported
- VI. Nurse Sensitive Performance Indicators
 - A. Continue to monitor research on nurse sensitive indicators
 - B. Select methodology for piloting and publicly reporting quality indicators for pressure ulcers
- VII. AHRQ Quality Indicators
 - A. Publicly report "Rhode Island Trends in AHRQ Quality Indicators for Patient Safety, Prevention, and Inpatient Quality"
- VIII. Annual Hospital Staffing Report
 - A. Collect annual core staffing plans
 - B. Create a workgroup to develop a format to be used for future data collection
- IX. Hospital Incident and Event Reporting
 - A. Collaborate with Facilities Regulation on the implementation of web-based data collection

- B. Incorporate incident and event reporting into the Health Care Quality Performance Measurement and Reporting Program
- X. Technical Expert Panel
 - A. Seek journal publication of technical expert panel review and recommendations
 - B. Develop a plan for a national conference on public reporting and seek funding from AHRQ for a small conference grant

XIII. Steering Committee Members (as of 12/1/05)

Ted Almon, President & CEO, Claflin Company
Kerrie Jones Clark, Executive Director, Rhode Island Health Center Association
Arthur Frazzano, MD, Associate Dean of Medical Clinical Faculty, Brown University
Neal Galinko, MD, MS, Medical Director, United Health Care of New England
David Gifford, MD, MPH, Director, Rhode Island Department of Health
Rep. Peter Ginaitt, Rhode Island House of Representatives
Roberta Hawkins, Executive Director, Alliance for Better Long Term Care
Linda McDonald, RN, President, United Nurses and Allied Professionals
Christopher Novak, Director, Rhode Island Association of Facilities and Services for Aging
Donna Policastro, RN, Interim Executive Director & President, Rhode Island State Nurses Association
Louis Pugliese, Performance Improvement Administrator, Eleanor Slater Hospital
Sharon Pugsley, Manager, Quality Improvement, Blue Cross Blue Shield of Rhode Island
Sharon Reniere, Assistant Administrator, Rhode Island Department of Human Services
Sen. Elizabeth Roberts, Rhode Island State Senate
Alfred Santos, Executive Vice President, Rhode Island Health Care Association
Marilyn Sayles, Principal Resource Specialist, Rhode Island Department of Elderly Affairs
Alan Tavares, Executive Director, Rhode Island Partnership for Home Health Care, Inc.
Robert Urciuoli, President, Roger Williams Medical Center

XIV. Program Staffing

Staffing changes occurred in the Health Care Quality Performance Measurement and Reporting Program. The program is now organizationally placed within the Center for Health Data and Analysis, under the direction of Jay Buechner, PhD. Dr. Buechner has assumed the responsibilities of William Waters, PhD, who continues in his role as Deputy Director of the Department of Health.

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**XV. Health Care Quality Performance Measurement and Reporting Program
Total Expenditures (Fiscal Years 2004 and 2005) and Budgeted (Fiscal Year 2006)**

FY04 Expenditures	FY05* Expenditures	FY06 Enacted Budget	FY06 Revised Budget
\$238,951	\$179,220	\$329,432	\$284,479

*Expenditures reduced due to extended vacancy in Program Director position.

XVI. Public Information

Health Care Quality Steering Committee minutes are posted on the Rhode Island Secretary of State's open meetings website. All meetings of the Health Care Quality Steering Committee and Subcommittees are posted on the Department of Health Website, www.health.ri.gov Calendar of Events. For additional information about the HCPMRP, please refer to the website: www.health.ri.gov/chic/performance/index.php.